Physician Related Services

Provided by:

Physicians, Mid-Level Practitioners, Podiatrists, Laboratories, Imaging Facilities, Independent Diagnostic Testing Facilities, and Public Health Clinics

Medicaid and Other Medical Assistance Programs

MONTANA
Department of Public Health & Human Services

April 2006

This publication supersedes all previous Physician, Mid-Level Practitioner, Podiatrist, Laboratory, Imaging Facility, Independent Diagnostic Testing Facility, and Public Health Clinic provider handbooks. Published by the Montana Department of Public Health & Human Services, July 2002.

Updated September 2002, January 2003, June 2003, August 2003, September 2003, December 2003, July 2004, September 2004, November 2004, January 2005, March 2005, September 2005, April 2006.

My Medicaid Provider ID Number:

My CHIP Provider ID Number:

Completing a Claim Form

The services described in this manual are billed either electronically on a Professional claim or on a CMS-1500 paper claim form. Claims submitted with all of the necessary information are referred to as "clean" and are usually paid in a timely manner (see the *Billing Procedure*s chapter in this manual).

Claims are completed differently for the different types of coverage a client has. This chapter includes instructions and a sample claim for each of the following scenarios:

- Client has Medicaid coverage only
- Client has Medicaid and Medicare coverage
- Client has Medicaid and third party liability coverage
- Client has Medicaid, Medicare, and third party liability coverage
- Client has Medicaid, Medicare, and Medicare supplement coverage

When completing a claim, remember the following:

- Required fields are indicated by "*".
- Fields that are required if the information is applicable to the situation or client are indicated by "**".
- Field 24h, *EPSDT/family planning*, is used as an indicator to specify additional details for certain clients or services. The following are accepted codes:

EPSDT/Family Planning Indicators

Code	Client/Service	Purpose
1	EPSDT	This indicator is used when the client is under age 21
2	Family planning	This indicator is used when providing family planning services.
3	EPSDT and family planning	This indicator is used when the client is under age 21 and is receiving family planning services
4	Pregnancy (any service provided to a pregnant woman)	This indicator is used when providing services to pregnant women
6	Nursing facility client	This indicator is used when providing services to nursing facility residents

- Unless otherwise stated, all paper claims must be mailed to the following address:

Claims Processing Unit
P.O. Box 8000
Helena, MT 59604

Client Has Medicaid Coverage Only

Field#	Field Title	Instructions
1	Program	Check Medicaid.
1a	Insured's ID number	Leave this field blank for Medicaid only claims.
2*	Patient's name	Enter the client's name as it appears on the Medicaid client's eligibility information.
3	Patient's birth date and sex	Client's birth date in month/day/year format. Check male or female box.
5	Patient's address	Client's address.
10	Is patient's condition related to:	Check "Yes" or "No" to indicate whether employment, auto liability, or other accident involvement applies to one or more of the services described in field 24. If you answered "yes" to any of these, enter the two-letter state abbreviation where the accident occurred on the "Place" line.
10d*	Reserved for local use	Enter the client's Medicaid ID number as it appears on the client's Medicaid eligibility information.
11d*	Is there another health benefit plan?	Enter "No". If "Yes", follow claim instructions for appropriate coverage later in this chapter.
14	Date of current illness, injury, pregnancy	Enter date in month/day/year format. This field is optional for Medicaid only claims.
16	Dates patient unable to work in current occupation	If applicable, enter date in month/day/year format. This field is optional for Medicaid only claims.
17	Name of referring physician	Enter the name of the referring physician. For PASSPORT clients, the name of the client's PASSPORT provider goes here.
17a**	ID number of referring physician	Enter the referring or ordering physician's Medicaid ID number. For PASSPORT clients, enter the client's PASSPORT provider's PASSPORT ID number.
18	Hospitalization dates related to current service	Enter dates if the medical service is furnished as a result of, or subsequent to, a related hospitalization. This field is optional for Medicaid only claims.
19	Reserved for local use	This field is used for any special messages regarding the claim or client.
20	Outside lab?	Check "No". Medicaid requires all lab tests to be billed directly by the provider who performed them.
21*	Diagnosis or nature of illness or injury	Enter the appropriate ICD-9-CM diagnosis codes. Enter up to four codes in priority order (primary, secondary, etc.).
23**	Prior authorization number	If the service requires prior authorization (PA), enter the PA number you received for this service.
24a*	Date(s) of service	Enter date(s) of service for each procedure, service, or supply.
24b*	Place of service	Enter the appropriate two-digit place of service (see *Appendix C*).
24c*	Type of service	Enter Montana's type of service code: Nursing facilities are "9", and all others are "0" (zero).
24d*	Procedure, service, or supplies	Enter the appropriate CPT-4 or HCPCS code for the procedure, service, or supply. When applicable, enter the appropriate CPT-4/HCPCS modifier. Medicaid allows up to three modifiers per procedure code.
24e*	Diagnosis code	Enter the corresponding diagnosis code **reference number** (1, 2, 3 or 4) from field 21 (do not enter the diagnosis code). Any combination of applicable diagnosis reference numbers may be listed on one line.
24f*	Charges	Enter your reasonable and customary charges (or the Department-designated charges) for the procedure(s) on this line.
24g*	Days or units	Enter the number of units or days for the procedure and date(s) of service billed on this line (see *Billing Procedures*, *Coding* for additional tips on days/units). Anesthesia providers must bill using minutes.
24h**	EPSDT/family planning	If applicable, enter the appropriate code for the client/service: 1, 2, 3, 4, or 6 (see complete description in the *EPSDT/Family Planning Indicators* table earlier in this chapter).
24i	EMG (Emergency)	Not used.
28*	Total charge	Enter the sum of all charges billed in field 24f.
29	Amount paid	Leave blank or enter $0.00. Do not report any client copay or Medicaid payment amounts on this form.
30	Balance due	Enter the balance due as recorded in field 28.
31*	Signature and date	This field must contain an authorized signature and date, which is either hand signed, stamped, or computer generated.
32	Name and address of facility	Enter the name and address of the person, organization, or facility performing the services if other than the client's home or physician's office.
33*	Physician's, supplier's billing name, address, phone number	Enter the name, address, phone number and Montana Medicaid provider number (not UPIN) of the physician or supplier who furnished service.

* = Required Field ** = Required if applicable

Client Has Medicaid Coverage Only

APPROVED OMB-0938-0008

For Medicaid use. Do not write in this area.

CARRIER

PICA

HEALTH INSURANCE CLAIM FORM

PICA

PATIENT AND INSURED INFORMATION

1. MEDICARE [ ] (Medicare #) MEDICAID [X] (Medicaid #) CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (VA File #) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Smith, Chuckie L.

3. PATIENT'S BIRTH DATE: 04 28 96 SEX: M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 123 Anystreet #1

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street)

CITY: Anytown STATE: MT

8. PATIENT STATUS: Single [X] Married [ ] Other [ ] Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

CITY STATE

ZIP CODE: 59999 TELEPHONE (Include Area Code): (406) 555-5555

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE: 999999999

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] ***If yes***, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY 09 10 00 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: Doug Ross, MD

17a. I.D. NUMBER OF REFERRING PHYSICIAN: 9989999

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 381.20
2. 474.12
3. 474.01
4. ____.__

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 03 18 02		24	0	69436	50	1	500 00	1				
2 03 18 02		24	0	42830	51	2,3	450 00	1				
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER: 99-9999999 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: 99999

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 950 00

29. AMOUNT PAID: $ 0 00

30. BALANCE DUE: $ 950 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Doug Ross, MD 03/20/02

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

Anytown Surgicenter
123 Medical Drive
Anytown, MT 59999

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

The Pediatric Center
P.O. Box 999
Anytown, MT 59999

PIN# 0000099999 GRP# (406) 555-5555

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

Client Has Medicaid and Medicare Coverage

Field#	Field Title	Instructions
1	Program	Check Medicaid.
1a*	Insured's ID number	Enter the client's Medicare ID number.
2*	Patient's name	Enter the client's name as it appears on the Medicaid client's eligibility information.
3	Patient's birth date and sex	Client's birth date in month/day/year format. Check male or female box.
4	Insured's name	Enter the name of the insured or "SAME".
5	Patient's address	Client's address.
7	Insured's address	Enter the insured's address and telephone number or "SAME".
10	Is patient's condition related to:	Check "Yes" or "No" to indicate whether employment, auto liability, or other accident involvement applies to one or more of the services described in field 24. If you answered "yes" to any of these, enter the two-letter state abbreviation where the accident occurred on the "Place" line.
10d*	Reserved for local use	Enter the client's Medicaid ID number as it appears on the client's Medicaid eligibility information.
11	Insured's policy group	This field should be blank.
11c	Insurance plan or program	This field should be blank.
11d*	Is there another health benefit plan?	Check "NO".
14	Date of current illness, injury, pregnancy	Enter date in month/day/year format.
16	Dates patient unable to work in current occupation	If applicable, enter date in month/day/year format.
17	Name of referring physician	Enter the name of the referring physician. For PASSPORT clients, the name of the client's PASSPORT provider goes here.
17a**	ID number of referring physician	Enter the referring or ordering physician's Medicaid ID number. For PASSPORT clients, enter the client's PASSPORT provider's PASSPORT ID number.
18	Hospitalization dates related to current service	Enter dates if the medical service is furnished as a result of, or subsequent to, a related hospitalization.
19	Reserved for local use	This field is used for any special messages regarding the claim or client.
20	Outside lab?	Check "No". Medicaid requires all lab tests to be billed directly by the provider who performed them.
21*	Diagnosis or nature of illness or injury	Enter the appropriate ICD-9-CM diagnosis codes. Enter up to four codes in priority order (primary, secondary, etc.).
23**	Prior authorization number	If the service requires prior authorization (PA), enter the PA number you received for this service.
24a*	Date(s) of service	Enter date(s) of service for each procedure, service, or supply.
24b*	Place of service	Enter the appropriate two-digit place of service (see *Appendix C*).
24c*	Type of service	Enter Montana's type of service code: Nursing facilities are "9", and all others are "0" (zero).
24d*	Procedure, service, or supplies	Enter the appropriate CPT-4 or HCPCS code for the procedure, service, or supply. When applicable, enter appropriate modifiers. Medicaid recognizes two pricing and one informational modifier per code.
24e*	Diagnosis code	Enter the corresponding diagnosis code **reference number** (1, 2, 3 or 4) from field 21 (do not enter the diagnosis code). Any combination of applicable diagnosis reference numbers may be listed on one line.
24f*	Charges	Enter your reasonable and customary charges (or the Department-designated charges) for the procedure(s) on this line.
24g*	Days or units	Enter the number of units or days for the procedure and date(s) of service billed on this line (see *Billing Procedures*, *Coding* for additional tips on days/units). Anesthesia providers must bill using minutes.
24h**	EPSDT/family planning	If applicable, enter the appropriate code for the client/service: 1, 2, 3, 4 or 6 (see complete description in the *EPSDT/Family Planning Indicators* table earlier in this chapter).
24i	EMG (Emergency)	Not used.
28*	Total charge	Enter the sum of all charges billed in field 24f.
29	Amount paid	Leave this field blank. Do not include any adjustment amounts or coinsurance. The Medicare payment amount will be determined from the EOMB attached to the claim.
30	Balance due	Enter the balance due as listed in field 28.
31*	Signature and date	This field must contain an authorized signature and date, which can be hand signed, stamped, or computer generated.
32	Name and address of facility	Enter the name and address of the person, organization, or facility performing the services if other than the client's home or physician's office.
33*	Physician's, supplier's billing name, address, phone number	Enter the name, address, phone number and Montana Medicaid provider number (not UPIN) of the physician or supplier who furnished service.

* = Required Field ** = Required if applicable

Client Has Medicaid and Medicare Coverage

APPROVED OMB-0938-0008

For Medicaid use. Do not write in this area.

CARRIER

PICA

HEALTH INSURANCE CLAIM FORM

PICA

PATIENT AND INSURED INFORMATION

1. MEDICARE [ ] (Medicare #) MEDICAID [X] (Medicaid #) CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (VA File #) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 999999999A

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Jones, Jerry

3. PATIENT'S BIRTH DATE: 02 04 33 SEX: M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Same

5. PATIENT'S ADDRESS (No., Street): 4321 Anystreet

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): Same

CITY: Anytown STATE: MT

8. PATIENT STATUS: Single [X] Married [ ] Other [ ]

CITY STATE

ZIP CODE: 59999 TELEPHONE (Include Area Code): (406) 555-9999

Employed [X] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE: 999999999

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] ***If yes***, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: Carter, Edward MD

17a. I.D. NUMBER OF REFERRING PHYSICIAN: 9999999

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 12 07 01 TO 12 24 01

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 486 . 3. . 2. . 4. .

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 12 07 01	12 07 01	21	0	99223		1	200 00	1				
2 12 08 01	12 08 01	21	0	99223		1	75 00	1				
3 12 09 01	12 09 01	21	0	99223		1	75 00	1				
4 12 10 01	12 10 01	21	0	99223		1	75 00	1				
5 12 13 01	12 13 01	21	0	99223		1	75 00	1				
6 12 15 01	12 15 01	21	0	99223		1	75 00	1				

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [X]: 99-9999999

26. PATIENT'S ACCOUNT NO.: 99999999ABC

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 575 00

29. AMOUNT PAID: $

30. BALANCE DUE: $ 575 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Edward Carter, MD 06/15/02

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

Anytown Hospital
12345 Medical Drive
Anytown, MT 59999

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

Family Healthcare
321 Medical Drive
Anytown, MT 59999

PIN# 9999999 GRP# (406) 555-5555

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE***

FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

Client Has Medicaid and Third Party Liability Coverage

Field#	Field Title	Instructions
1	Program	Check Medicaid.
1a*	Insured's ID number	Enter the client's ID number for the primary carrier.
2*	Patient's name	Enter the client's name as it appears on the Medicaid client's eligibility information.
3	Patient's birth date and sex	Client's birth date in month/day/year format. Check male or female box.
4	Insured's name	Enter the name of the insured or "SAME".
5	Patient's address	Client's address.
7	Insured's address	Enter the insured's address and telephone number or "SAME".
9 -9d	Other insured's information	Use these fields only if there are two or more third party insurance carriers (not including Medicaid and Medicare).
10	Is patient's condition related to:	Check "Yes" or "No" to indicate whether employment, auto liability, or other accident involvement applies to one or more of the services described in field 24. If you answered "yes" to any of these, enter the two-letter state abbreviation where the accident occurred on the "Place" line.
10d*	Reserved for local use	Enter the client's Medicaid ID number as it appears on the client's Medicaid eligibility information.
11	Insured's policy group	Leave this field blank, or enter the client's ID number for the primary payer.
11c*	Insurance plan or program	Enter the name of the other insurance plan or program (i.e. BlueCross BlueShield, New West, etc.).
11d*	Is there another health benefit plan?	Check "YES".
14	Date of current illness, injury, pregnancy	Enter date in month/day/year format.
16	Dates patient unable to work in current occupation	If applicable, enter date in month/day/year format.
17	Name of referring physician	Enter the name of the referring physician. For PASSPORT clients, the name of the client's PASSPORT provider goes here.
17a**	ID number of referring physician	Enter the referring or ordering physician's Medicaid ID number. For PASSPORT clients, enter the client's PASSPORT provider's PASSPORT ID number.
18	Hospitalization dates related to current service	Enter dates if the medical service is furnished as a result of, or subsequent to, a related hospitalization.
19	Reserved for local use	This field is used for any special messages regarding the claim or client.
20	Outside lab?	Check "No". Medicaid requires all lab tests to be billed directly by the provider who performed them.
21*	Diagnosis or nature of illness or injury	Enter the appropriate ICD-9-CM diagnosis codes. Enter up to four codes in priority order (primary, secondary, etc.).
23**	Prior authorization number	If the service requires prior authorization (PA), enter the PA number you received for this service.
24a*	Date(s) of service	Enter date(s) of service for each procedure, service, or supply.
24b*	Place of service	Enter the appropriate two-digit place of service (see *Appendix C*).
24c*	Type of service	Enter Montana's type of service code: Nursing facilities are "9", and all others are "0" (zero).
24d*	Procedure, service, or supplies	Enter the appropriate CPT-4 or HCPCS code for the procedure, service, or supply. When applicable, enter appropriate modifiers. Medicaid recognizes two pricing and one informational modifier per code.
24e*	Diagnosis code	Enter the corresponding diagnosis code **reference number** (1, 2, 3 or 4) from field 21 (do not enter the diagnosis code). Any combination of applicable diagnosis reference numbers may be listed on one line.
24f*	Charges	Enter your reasonable and customary charges (or the Department-designated charges) for the procedure(s) on this line.
24g*	Days or units	Enter the number of units or days for the procedure and date(s) of service billed on this line (see *Billing Procedures*, *Coding* for additional tips on days/units). Anesthesia providers must bill using minutes.
24h**	EPSDT/family planning	If applicable, enter the appropriate code for the client/service: 1, 2, 3, 4 or 6 (see complete description in the *EPSDT/Family Planning Indicators* table earlier in this chapter).
24i	EMG (Emergency)	Not used.
28*	Total charge	Enter the sum of all charges billed in field 24f.
29*	Amount paid	Enter the amount paid by the other insurance. Do not include any adjustment amounts or coinsurance.
30*	Balance due	Enter the balance due (the amount in field 28 less the amount in field 29).
31*	Signature and date	This field must contain an authorized signature and date, which can be hand signed, stamped, or computer generated.
32	Name and address of facility	Enter the name and address of the person, organization, or facility performing the services if other than the client's home or physician's office.
33*	Physician's, supplier's billing name, address, phone number	Enter the name, address, phone number and Montana Medicaid provider number (not UPIN) of the physician or supplier who furnished service.

* = Required Field ** = Required if applicable

Client Has Medicaid and Third Party Liability Coverage

PLEASE DO NOT STAPLE IN THIS AREA

APPROVED OMB-0938-0008

For Medicaid use. Do not write in this area.

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE [ ] (Medicare #) MEDICAID [X] (Medicaid #) CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (VA File #) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 999999999B

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Jackson, Renee P.

3. PATIENT'S BIRTH DATE MM DD YY: 08 31 80 SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Same

5. PATIENT'S ADDRESS (No., Street): 4321 Anystreet

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): Same

CITY: Anytown STATE: MT

8. PATIENT STATUS: Single [X] Married [ ] Other [ ]

CITY STATE

ZIP CODE: 59999 TELEPHONE (Include Area Code): (406)999-9999

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: 999999999B

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [ ]

a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME: Paywell Insurance

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE: 9999999

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [X] YES [ ] NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY 01 16 02 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: Smith, Steven R. MD

17a. I.D. NUMBER OF REFERRING PHYSICIAN: 9999999

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 845.02 3. ____.__

2. ____.__ 4. ____.__

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 01 16 02	01 16 02	11	0	99203		1	75 00	1				
2 01 16 02	01 16 02	11	0	73610		1	45 00	1				
3 01 16 02	01 16 02	11	0	L1930		1	125 00	1				
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ]

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [ ]

28. TOTAL CHARGE $ 245 00

29. AMOUNT PAID $ 129 00

30. BALANCE DUE $ 116 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

John Pied, DPM 01/16/02

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

The Foot Group
25 Medical Drive
Anytown, MT 59999

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

The Foot Group
P.O. Box 999
Anytown, MT 59999

PIN# 999999 GRP# (406) 999-9999

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

Client Has Medicaid, Medicare, and Third Party Liability Coverage

Field#	Field Title	Instructions
1	Program	Check Medicaid.
1a*	Insured's ID number	Enter the client's Medicare ID number.
2*	Patient's name	Enter the client's name as it appears on the Medicaid client's eligibility information.
3	Patient's birth date and sex	Client's birth date in month/day/year format. Check male or female box.
4	Insured's name	Enter the name of the insured or "SAME".
5	Patient's address	Client's address.
7	Insured's address	Enter the insured's address and telephone number or "SAME".
9 -9d	Other insured's information	Use these fields only if there are two or more third party insurance carriers (not including Medicaid and Medicare).
10	Is patient's condition related to:	Check "Yes" or "No" to indicate whether employment, auto liability, or other accident involvement applies to one or more of the services described in field 24. If you answered "yes" to any of these, enter the two-letter state abbreviation where the accident occurred on the "Place" line.
10d*	Reserved for local use	Enter the client's Medicaid ID number as it appears on the client's Medicaid eligibility information.
11*	Insured's policy group	Enter the client's primary payer (TPL) ID number.
11c*	Insurance plan or program	Enter the name of the primary payer.
11d*	Is there another health benefit plan?	Check "YES".
14	Date of current illness, injury, pregnancy	Enter date in month/day/year format.
16	Dates patient unable to work in current occupation	If applicable, enter date in month/day/year format.
17	Name of referring physician	Enter the name of the referring physician. For PASSPORT clients, the name of the client's PASSPORT provider goes here.
17a**	ID number of referring physician	Enter the referring or ordering physician's Medicaid ID number. For PASSPORT clients, enter the client's PASSPORT provider's PASSPORT ID number.
18	Hospitalization dates related to current service	Enter dates if the medical service is furnished as a result of, or subsequent to, a related hospitalization.
19	Reserved for local use	This field is used for any special messages regarding the claim or client.
20	Outside lab?	Check "No". Medicaid requires all lab tests to be billed directly by the provider who performed them.
21*	Diagnosis or nature of illness or injury	Enter the appropriate ICD-9-CM diagnosis codes. Enter up to four codes in priority order (primary, secondary, etc.).
23**	Prior authorization number	If the service requires prior authorization (PA), enter the PA number you received for this service.
24a*	Date(s) of service	Enter date(s) of service for each procedure, service, or supply.
24b*	Place of service	Enter the appropriate two-digit place of service (see *Appendix C*).
24c*	Type of service	Enter Montana's type of service code: Nursing facilities are "9", and all others are "0" (zero).
24d*	Procedure, service, or supplies	Enter the appropriate CPT-4 or HCPCS code for the procedure, service, or supply. When applicable, enter appropriate modifiers. Medicaid recognizes two pricing and one informational modifier per code.
24e*	Diagnosis code	Enter the corresponding diagnosis code **reference number** (1, 2, 3 or 4) from field 21 (do not enter the diagnosis code). Any combination of applicable diagnosis reference numbers may be listed on one line.
24f*	Charges	Enter your reasonable and customary charges (or the Department-designated charges) for the procedure(s) on this line.
24g*	Days or units	Enter the number of units or days for the procedure and date(s) of service billed on this line (see *Billing Procedures*, *Coding* for additional tips on days/units). Anesthesia providers must bill using minutes.
24h**	EPSDT/family planning	If applicable, enter the appropriate code for the client/service: 1, 2, 3, 4 or 6 (see complete description in the *EPSDT/Family Planning Indicators* table earlier in this chapter).
24i	EMG (Emergency)	Not used.
28*	Total charge	Enter the sum of all charges billed in field 24f.
29*	Amount paid	Enter the amount paid by the primary payer (not Medicare). Do not include any adjustment amounts or coinsurance. The Medicare payment amount will be determined from the EOMB attached to the claim.
30*	Balance due	Enter the balance due (the amount in field 28 less the amount in field 29).
31*	Signature and date	This field must contain an authorized signature and date, which can be hand signed, stamped, or computer generated.
32	Name and address of facility	Enter the name and address of the person, organization, or facility performing the services if other than the client's home or physician's office.
33*	Physician's, supplier's billing name, address, phone number	Enter the name, address, phone number and Montana Medicaid provider number (not UPIN) of the physician or supplier who furnished service.

* = Required Field ** = Required if applicable

Client Has Medicaid, Medicare, and Third Party Liability Coverage

PLEASE DO NOT STAPLE IN THIS AREA

APPROVED OMB-0938-0008

For Medicaid use. Do not write in this area.

CARRIER

PICA

HEALTH INSURANCE CLAIM FORM

PICA

PATIENT AND INSURED INFORMATION

1. MEDICARE [ ] (Medicare #) MEDICAID [X] (Medicaid #) CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (VA File #) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 999999999

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Olsen, Karen Z.

3. PATIENT'S BIRTH DATE: 11 07 62 SEX: M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Same

5. PATIENT'S ADDRESS (No., Street): 98765 Anystreet #2

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): Same

CITY: Anytown STATE: MT

8. PATIENT STATUS: Single [X] Married [ ] Other [ ]

CITY: STATE:

ZIP CODE: 59999 TELEPHONE (Include Area Code): (406) 999-9999

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE: TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: 999999999A

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME: Paywell Insurance

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE: 999999999

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [X] NO [ ] *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY 06 23 02 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 690.10
2. 078.10
3. ____.__
4. ____.__

22. MEDICAID RESUBMISSION CODE: ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 12 20 01	12 20 01	11	0	17110		1,2	79 20	1				
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER: 99-9999999 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.:

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 79 20

29. AMOUNT PAID: $ 32 00

30. BALANCE DUE: $ 47 20

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Steven Sloan, MD 01/31/02

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

Steven Sloan, MD
P.O. Box 999
Anytown, MT 59999

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

Steven Sloan, MD
P.O. Box 999
Anytown, MT 59999

PIN# 999999 GRP# (406) 999-9999

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE***

FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

Client Has Medicaid, Medicare, and Medicare Supplement Coverage

Field#	Field Title	Instructions
1	Program	Check Medicaid.
1a*	Insured's ID number	Enter the client's Medicare ID number.
2*	Patient's name	Enter the client's name as it appears on the Medicaid client's eligibility information.
3	Patient's birth date and sex	Client's birth date in month/day/year format. Check male or female box.
4	Insured's name	Enter the name of the insured or "SAME".
5	Patient's address	Client's address.
7	Insured's address	Enter the insured's address and telephone number or "SAME".
9 -9d	Other insured's information	Use these fields only if there are two or more third party insurance carriers (not including Medicaid and Medicare).
10	Is patient's condition related to:	Check "Yes" or "No" to indicate whether employment, auto liability, or other accident involvement applies to one or more of the services described in field 24. If you answered "yes" to any of these, enter the two-letter state abbreviation where the accident occurred on the "Place" line.
10d*	Reserved for local use	Enter the client's Medicaid ID number as it appears on the client's Medicaid eligibility information.
11*	Insured's policy group	Enter the client's ID number for the primary payer.
11c*	Insurance plan or program	Enter the name of the other insurance plan or program (i.e. BlueCross BlueShield, New West, etc.).
11d*	Is there another health benefit plan?	Check "YES".
14	Date of current illness, injury, pregnancy	Enter date in month/day/year format.
16	Dates patient unable to work in current occupation	If applicable, enter date in month/day/year format.
17	Name of referring physician	Enter the name of the referring physician. For PASSPORT clients, the name of the client's PASSPORT provider goes here.
17a**	ID number of referring physician	Enter the referring or ordering physician's Medicaid ID number. For PASSPORT clients, enter the client's PASSPORT provider's PASSPORT ID number.
18	Hospitalization dates related to current service	Enter dates if the medical service is furnished as a result of, or subsequent to, a related hospitalization.
19	Reserved for local use	This field is used for any special messages regarding the claim or client.
20	Outside lab?	Check "No". Medicaid requires all lab tests to be billed directly by the provider who performed them.
21*	Diagnosis or nature of illness or injury	Enter the appropriate ICD-9-CM diagnosis codes. Enter up to four codes in priority order (primary, secondary, etc.).
23**	Prior authorization number	If the service requires prior authorization (PA), enter the PA number you received for this service.
24a*	Date(s) of service	Enter date(s) of service for each procedure, service, or supply.
24b*	Place of service	Enter the appropriate two-digit place of service (see *Appendix C*).
24c*	Type of service	Enter Montana's type of service code: Nursing facilities are "9", and all others are "0" (zero).
24d*	Procedure, service, or supplies	If applicable, enter the appropriate CPT-4 or HCPCS code for the procedure, service, or supply. When applicable, enter appropriate modifiers. Medicaid recognizes two pricing and one informational modifier per code.
24e*	Diagnosis code	Enter the corresponding diagnosis code **reference number** (1, 2, 3 or 4) from field 21 (do not enter the diagnosis code). Any combination of applicable diagnosis reference numbers may be listed on one line.
24f*	Charges	Enter your reasonable and customary charges (or the Department-designated charges) for the procedure(s) on this line.
24g*	Days or units	Enter the number of units or days for the procedure and date(s) of service billed on this line (see *Billing Procedures*, *Coding* for additional tips on days/units). Anesthesia providers must bill using minutes.
24h**	EPSDT/family planning	Enter the appropriate code for the client/service: 1, 2, 3, 4 or 6 (see complete description in the *EPSDT/ Family Planning Indicators* table earlier in this chapter).
24i	EMG (Emergency)	Not used.
28*	Total charge	Enter the sum of all charges billed in field 24f.
29*	Amount paid	Enter the amount paid by the Medicare supplement insurance only. Do not include any adjustment amounts or coinsurance. Medicare payment is determined from the EOMB attached to the claim.
30*	Balance due	Enter balance due (amount in field 28 less the amount in field 29).
31*	Signature and date	This field must contain an authorized signature and date, which can be hand signed, stamped, or computer generated.
32	Name and address of facility	Enter the name and address of the person, organization, or facility performing the services if other than the client's home or physician's office.
33*	Physician's, supplier's billing name, address, phone number	Enter the name, address, phone number and Montana Medicaid provider number (not UPIN) of the physician or supplier who furnished service.

* = Required Field ** = Required if applicable

Time units

A unit of time for anesthesia is 15 minutes, though Medicaid does pay for partial units. Providers enter the number of minutes on the claim; the claims processing contractor then converts the minutes to time units.

Base units

Base units are adopted by Medicaid from the schedule of base units used by Medicare, which in turn is reflects base units calculated by the American Society of Anesthesiologists. Providers do not enter the number of base units on the claim.

Fee calculation

For a particular service, Department payment is calculated as follows:

(Time units + base units) x anesthesia conversion factor = payment

For anesthesia for a wrist operation (01820), for example, the number of base units is 3. If the anesthesiologist spends 60 minutes with the patient then payment would be:

[4 + 3] x conversion factor of $26.25 = $183.75

The only exceptions are several codes for which time units do not apply. These codes are paid via the RBRVS fee schedule, with the relative values being set by the Department so that the fee equals the number of anesthesia base units x the anesthesia conversion factor.

Transitional conversion factor

Although the terminology is similar to the RBRVS, the two sets of relative values represent two different ways of comparing services. Accordingly, the Medicare program uses a different conversion factor for anesthesia services; in Montana in 2002 it is $15.11. Because of the legislatively mandated transition described above, the Medicaid conversion factor in July 2002 is $26.25. Without the transition, the Medicaid conversion factor would be $15.11.

Policy adjustor

Anesthesia codes for maternity and family planning procedures are paid 10% more than they would otherwise be paid.

Modifiers

Payment for anesthesia services is affected by the modifier pricing rules shown in the accompanying table; take note of the modifiers for anesthesia care provided under medical supervision. Medicaid follows Medicare in not paying extra for the patient status modifiers P1 to P6.

The numerical examples on this page do not reflect current rates and should not be used to calculate payment.

When billing Medicaid for anesthesia services, enter the number of minutes in the "Units" field of the CMS-1500 claim form.

The numerical examples on this page do not reflect current rates and should not be used to calculate payment.

Professional differentials

In general, certified registered nurse anesthetists (CRNAs) receive 90% of the fee that a physician would receive for the same case. The exception is that CRNAs receive 100% of the fee for immunizations, family planning, drugs paid via HCPCS Level II codes, services to clients under age 21 (i.e., Well Child EPSDT services), lab and pathology services, radiology, cardiography and echocardiography (per ARM 37.86.205(6)).

Charge cap

The Department pays the lower of the provider's charge and the amount as calculated above.

Payment by report

Base units have not been developed for unlisted anesthesia services. These services are paid at a percentage of charges; in July 2002 the percentage was 51%.

Clinical Lab Services (ARM 37.85.212)

In general, Medicaid pays the same fees for clinical lab services as Medicare does in Montana. If a Medicare fee is not available for a lab test covered by Medicaid, then payment is calculated by looking at the average charge and the amounts paid by other payers.

Vaccines and Drugs Provided Within the Office

Many vaccines are available for free to physician offices through the Vaccines for Children (VFC) program. For more information on how to obtain these vaccines, call (406) 444-5580. For these vaccines, the Department does not pay separately. Medicaid does pay for the administration of the vaccine, however. For more information, see the *Billing Procedures* chapter in this manual.

Medicaid pays for vaccines not available through the VFC program, and for other drugs that have to be administered within the office or clinic setting. Medicaid pays average wholesale price less 15% for drugs. Average wholesale price is calculated by National Drug Code, a detailed coding system that is not shown on CMS-1500 bills. Instead, the bills show HCPCS Level 2 codes; almost all drugs are coded in the J series (for example, J2345). When a J code closely matches the NDC code for a particular drug, Medicaid pays for the drug directly. For other J codes, however, the claims processing system denies the line and requests that the provider send the NDC or invoice to the Department so that payment may be calculated.

How Cost Sharing Is Calculated on Medicaid Claims

Client cost sharing fees are a set dollar amount per visit (see the *Billing Procedures* chapter, *Client Cost Sharing,* for more information and a chart showing cost sharing amount by provider type). The client's cost sharing amount is shown on the remit-

tance advice and deducted from the Medicaid allowed amount (see the *Remittance Advices and Adjustments* chapter in this manual). For example, a physician removes a bunion from a client's foot (28290) in her office. The Medicaid allowed amount in July 2002 for this procedure is $456.71. The client would owe the physician $4.00 for cost sharing, and Medicaid would pay the provider the remaining $452.71.

The numerical examples on this page do not reflect current rates and should not be used to calculate payment.

How Payment Is Calculated on TPL Claims

When a client has coverage from both Medicaid and another insurance company, the other insurance company is often referred to as third party liability or TPL. In these cases, the other insurance is the primary payer (as described in the C*oordination of Benefits* chapter of this manual), and Medicaid makes a payment as the secondary payer. For example, a mid-level practitioner provides a Level 2 office visit (99212) to a client who also has insurance through her job. The client's other insurance is billed first and pays $24.25. The Medicaid allowed amount for this service is $28.90. The amount the other insurance paid ($24.25) is subtracted from the Medicaid allowed amount ($28.90), leaving a balance of $4.65, which Medicaid will pay on this claim.

Total payment to the provider from all sources may not exceed the Medicaid allowed amount.

How Payment Is Calculated on Medicare Crossover Claims

When a client has coverage from both Medicaid and Medicare, Medicare is the primary payer as described in the *Coordination of Benefits* chapter of this manual. Medicaid then makes a payment as the secondary payer. For the provider types covered in this manual, Medicaid's payment is calculated so that the total payment to the provider is either the Medicaid allowed amount less the Medicare paid amount or the sum of the Medicare coinsurance and deductible, whichever is lower. This method is sometimes called "lower of" pricing. The following scenarios are examples of how a Medicare crossover claim is paid. Medicaid incurment is not considered in the following examples. These are only examples and may not reflect current rates.

Summary of Crossover Payment Scenarios

Scenario	Client Has Met Medicare Deductible	Medicare Paid Amount Is Less Than Medicaid Allowed Amount	Mental Health Service
1	Yes	Yes	No
2	No	Yes	No
3	Yes	No	No
4	No	Yes	No
5	Yes	Yes	Yes

Scenario 1: Dually eligible client, Medicare paid amount is lower than Medicaid allowed amount, client has already met Medicare deductible.

The numerical examples on this page do not reflect current rates and should not be used to calculate payment.

Scenario 1

$ 32.81 Medicare allow.
x 80% Medicare rate
$ 26.25 Medicare paid

$ 32.81 Medicare allow.
- 26.25 Medicare paid
$ 6.56 Medicare coinsurance

$ 28.90 Medicaid allow.
- 26.25 Medicare paid
$ 2.65

$2.65 < $6.56
$2.65 Medicaid pays

A physician provides a Level 2 visit in her office to a client who is eligible for both Medicare and Medicaid. The client has already met Medicare's requirement for a $100 deductible per year. The Medicare allowed amount for this service (99212) is $32.81. As usual, the Medicare program pays the physician 80% of this amount, or $26.25. The client would be personally responsible for the balance (or coinsurance) of $6.56, except that he has Medicaid as secondary coverage.

Medicaid's allowed amount for this service is $28.90. Because Medicare already paid $26.25, that would leave a difference of $2.65. Medicaid then compares the coinsurance amount ($6.56) to the Medicaid balance ($2.65) and pays the lower of the two amounts. The provider will receive $2.65 from Medicaid for this claim.

Scenario 2: Dually eligible client, Medicare paid amount is lower than Medicaid allowed amount, client has not met Medicare deductible.

Providers cannot bill Medicaid clients for the difference between charges and the amount Medicaid paid.

This scenario is the same as Scenario 1, except that the client has not yet met his $100 Medicare deductible. The Medicare allowed amount is $32.81, but because that amount is applied to the client's deductible, Medicare pays zero. The Medicaid allowed amount is $28.90. Medicaid will pay the lower of $32.81 and $28.90. Medicaid will pay the provider $28.90 for this claim.

Scenario 2

$ 32.81 Medicare allowed
- 32.81 Applied to deductible
$ 0.00 Medicare paid

$ 28.90 Medicaid allowed
- 0.00 Medicare paid
$ 28.90

$28.90 < $32.81
$28.90 Medicaid pays

Scenario 3: Dually eligible client, Medicare paid amount is higher than Medicaid allowed amount, client has met Medicare deductible.

A physician provided a Level 4 office visit (99214) to a client who is eligible for Medicare and Medicaid. The Medicare allowed amount is $72.01, which Medicare pays at 80% for $57.61. This leaves the client with a $14.40 Medicare coinsurance.

Scenario 3

$ 72.01 Medicare allow.
x 80% Medicare rate
$ 57.61 Medicare paid

$ 72.01 Medicare allow.
- 57.61 Medicare paid
$14.40 Medicare coinsurance

$ 50.66 Medicaid allow.
- 57.61 Medicare paid
$ -6.95 Negative value = 0

$0 < $14.40
$0 Medicaid pays

The Medicaid allowed amount is $50.66. Because Medicare paid $57.61, this would leave a difference of $-6.95. Medicaid considers this negative value equal to $0. Medicaid then compares the coinsurance balance ($14.40) to the Medicaid balance ($0) and pays the lower of the two amounts. Medicaid would pay the provider $0.00 for this claim.

Scenario 4: Dually eligible client, Medicare paid amount is lower than Medicaid allowed amount, client has not met Medicare deductible.

Scenario 4

$136.09 Medicare allow.
-100.00 Medicare deductible
$ 36.09 Medicare balance

$36.09 Medicare balance
x 80% Medicare rate
$28.87 Medicare paid

$36.09 Medicare balance
-28.87 Medicare paid
$ 7.22 Medicare coinsurance

$100.00 Medicare deductible
+ 7.22 Medicare coinsurance
$107.22

$163.12 Medicaid allow.
- 28.87 Medicare paid
$ 134.25

$107.22 < $134.25
$107.22 Medicaid paid

An otolaryngologist performs a tympanostomy on a client who is eligible for both Medicare and Medicaid. The client has not yet met his $100 Medicare deductible. The Medicare allowed amount for this service (69436) is $136.09. Since the client owes $100 for the deductible, Medicare pays 80% of the remaining $36.09 ($28.87), leaving the client with a Medicare coinsurance of $7.22.

Medicaid considers the $100 that was applied to the client's Medicare deductible and adds it to the $7.22 coinsurance for a total of $107.22. Medicaid then subtracts the amount Medicare paid ($28.87) from the Medicaid allowed amount ($163.12) for a total of $134.25 Medicaid compares the $107.22 to the $134.25, and pays the lower of the two amounts. Medicaid will pay the provider $107.22 for this claim.

The numerical examples on this page do not reflect current rates and should not be used to calculate payment.

The numerical examples on this page do not reflect current rates and should not be used to calculate payment.

Scenario 5: Mental health service, dually eligible client, Medicare allowed amount is lower than Medicaid allowed amount, client has met Medicare deductible.

Scenario 5
$ 69.14 Medicare allow.
x 80% Medicare rate
$ 55.31
x 62.5% Mental health rate
$ 34.57 Medicare paid
$69.14 Medicare allow.
- 34.57 Medicare paid
$ 34.56 Medicare coinsurance
$ 80.71 Medicaid allow.
- 69.14 Medicare allow.
$ 11.57
$11.57 < $34.56
$11.57 Medicaid paid

A psychiatrist provides psychotherapy with medical evaluation and management (90805) for a client who is eligible for both Medicare and Medicaid and has already met the Medicare deductible. The Medicare allowed amount for this procedure is $69.14. Medicare calculates the payment amount for mental health services at 62.5% of 80%, so Medicare paid $34.57. The Medicare allowed amount ($69.14) less the Medicare paid ($34.57) leaves the client with a $34.56 Medicare coinsurance balance.

Medicaid subtracts the Medicare allowed ($69.14) from the Medicaid allowed amount ($80.71) for a balance of $11.57. Medicaid compares the $11.57 to the client coinsurance ($34.56), and pays the lower of the two. Medicaid will pay $11.57 for this claim.

Other Department Programs

The payment method described in this chapter also applies to services provided under the Mental Health Services Plan; as noted above, psychiatrists receive 125% of the fee schedule for designated mental health services. The payment method does not apply to services provided under the Children's Health Insurance Plan.

Definitions and Acronyms

This section contains definitions, abbreviations, and acronyms used in this manual.

270/271 Transactions
The ASC X12N eligibility inquiry (270) and response (271) transactions.

276/277 Transactions
The ASC X12N claim status request (276) and response (277) transactions.

278 Transactions
The ASC X12N request for services review and response used for prior authorization.

835 Transactions
The ASC X12N payment and remittance advice (explanation of benefits) transaction.

837 Transactions
The ASC X12N professional, institutional, and dental claim transactions (each with its own separate Implementation Guide).

Accredited Standards Committee X12, Insurance Subcommittee (ASC X12N)
The ANSI-accredited standards development organization, and one of the six Designated Standards Maintenance Organizations (DSMO), that has created and is tasked to maintain the administrative and financial transactions standards adopted under HIPAA for all health plans, clearinghouses, and providers who use electronic transactions.

Administrative Rules of Montana (ARM)
The rules published by the executive departments and agencies of the state government.

Allowed Amount
The maximum amount reimbursed to a provider for a health care service as determined by Medicaid or another payer. Other cost factors, (such as cost sharing, TPL, or incurment) are often deducted from the allowed amount before final payment. Medicaid's allowed amount for each covered service is listed on the Department fee schedule.

Ancillary Provider
Any provider that is subordinate to the client's primary provider, or providing services in the facility or institution that has accepted the client as a Medicaid client.

Assignment of Benefits
A voluntary decision by the client to have insurance benefits paid directly to the provider rather than to the client. The act requires the signing of a form for the purpose. The provider is not obligated to accept an assignment of benefits. However, the provider may require assignment in order to protect the provider's revenue.

Authorization
An official approval for action taken for, or on behalf of, a Medicaid client. This approval is only valid if the client is eligible on the date of service.

Basic Medicaid
Patients with Basic Medicaid have limited Medicaid services. See the *General Information For Providers* manual, *Appendix A: Medicaid Covered Services*.

Cash Option
Cash option allows the client to pay a monthly premium to Medicaid and have Medicaid coverage for the entire month rather than a partial month.

Centers for Medicare and Medicaid Services (CMS)
Administers the Medicare program and oversees the state Medicaid programs. Formerly the Health Care Financing Administration (HCFA).

Children's Health Insurance Plan (CHIP)
This plan covers some children whose family incomes make them ineligible for Medicaid. DPHHS sponsors the program, which is administered by BlueCross BlueShield of Montana.

Clean Claim
A claim that can be processed without additional information from or action by the provider of the service.

Client
An individual enrolled in a Department medical assistance program.

Code of Federal Regulations (CFR)
Rules published by executive departments and agencies of the federal government.

Coinsurance
The client's financial responsibility for a medical bill as assigned by Medicaid or Medicare (usually a percentage). Medicaid coinsurance is usually 5% of the Medicaid allowed amount, and Medicare coinsurance is usually 20% of the Medicare allowed amount.

Conversion Factor
A state specific dollar amount that converts relative values into an actual fee. This calculation allows each payer to adopt the RBRVS to its own economy.

Copayment
The client's financial responsibility for a medical bill as assigned by Medicaid (usually a flat fee).

Cosmetic
Serving to modify or improve the appearance of a physical feature, defect, or irregularity.

Cost Sharing
The client's financial responsibility for a medical bill assessed by flat fee.

Crossovers
Claims for clients who have both Medicare and Medicaid. These claims may come electronically from Medicare or directly from the provider.

DPHHS, State Agency
The Montana Department of Public Health and Human Services (DPHHS or Department) is the designated State Agency that administers the Medicaid program. The Department's legal authority is contained in Title 53, Chapter 6 MCA. At the Federal level, the legal basis for the program is contained in Title XIX of the Social Security Act and Title 42 of the Code of Federal Regulations (CFR). The program is administered in accordance with the Administrative Rules of Montana (ARM), Title 37, Chapter 86.

Dual Eligibles
Clients who are covered by Medicare and Medicaid are often referred to as "dual eligibles."